

Tool 1 – Ethical Considerations

Pandemic Influenza: Ethical Considerations

Introduction

In any disaster, the primary ethical obligation of public health officials is to plan. In response to the potential for pandemic flu, Santa Clara County Public Health Department has developed a plan for the design and implementation of Influenza Care Centers (ICCs). This tool provides an overview of ethical considerations germane to pandemic flu preparation and planning.

Purpose

The purpose of this tool is twofold:

- (1) To address some of the ethical considerations underlying the planning and development of an Influenza Care Center Plan (ICCP) and,
- (2) To aid disaster planners in Santa Clara County and elsewhere to incorporate ethical deliberations into pandemic planning. The tragedy of a pandemic will be exacerbated if ethical questions are ignored. Preparedness, justice as fairness, autonomy, and the 'common good' are suggested as guiding principles. Medical science and public health can provide information valuable to decision making; they are insufficient as the sole basis in a crisis. Urgent medical needs, scarcity of resources, and panic must not drive decision making. Planning involves assumptions about core values, guiding principles, and individual and local needs.

Other salient considerations are beyond the scope of this tool, but should be incorporated into mass care disaster planning efforts:

- Duty of health care professionals to provide care
- Provision of legal protection for these health care professionals
- Restrictions of individual freedoms, social distancing, isolation, and quarantine.

The "common good" refers to interests of a group or collective. This is defined by having in common certain attributes (e.g., location in geographically-defined community, specific disease risk) that create a commonality of interests. Herein, the term reflects an understanding that in case of an influenza pandemic, all human beings are part of single, collective that has a 'common good'.

(Kinlaw & Levine, CDC, 2007:4).

Ethical Preparedness: Background

Public health emergencies raise serious ethical issues central to societal and individual well-being and the public perception of fairness. In 2003, the outbreak and aftermath of Severe Acute Respiratory Syndrome (SARS) brought attention to the importance of establishing an ethical framework for decision making well in advance of any foreseeable medical disaster. This event exposed the problems that may arise when ethical presuppositions are not explicitly identified, e.g., the loss of public trust, poor hospital staff morale, confusion about roles and responsibilities, stigmatization of vulnerable communities, and misinformation. (Thompson, 2006: 2).

The often cited Canadian report, *Stand on Guard for Thee*, by the University of Toronto Joint Centre for Bioethics, was written after the SARS crisis of 2003. It illustrates an important set of ethical considerations to be used in preparing and planning for pandemic influenza. As the SARS crisis worsened and more restrictions were imposed, people became increasingly concerned about whose values should guide the decision-making processes in a public health emergency. People are more likely to accept decisions made by their leaders if the decision-making processes are reasonable, open and transparent, inclusive, responsive, and accountable, and if reciprocal obligations are respected. The report suggests that a previously established ethical framework can assist public health officials and government leaders to make better-informed decisions in a quickly overwhelming health crisis, like pandemic flu. It may also serve to increase public trust and morale, alleviate fear, and reduce the amount of disseminated misinformation.

(University of Toronto, 2005: 4).

Pandemic Influenza: Planning

The Centers for Disease Control (CDC) addressed ethical issues in pandemic planning in their February, 2007 document, “Ethical Guidelines in Pandemic Influenza.” The goal was to inform public decision making regarding pandemic influenza. Preserving the functioning of society is the over-riding, guiding principle in pandemic influenza management. The CDC designates the following for priority in distribution of vaccine, antivirals, and other scarce resources:

Individuals essential to:

- Provision of health care
- Public safety
- Functioning of key aspects of society

(Kinlaw & Levine, CDC, 2007: 3)

Diverse stakeholders must affirm, determine who is considered *key*, and establish a distribution strategy. This hierarchy is in contrast to the historical approach proposed during inter-pandemic years, i.e., to minimize serious influenza associated complications, including hospitalizations and death.

To foster public commitment and trust in a disaster plan, three primary ethical obligations must be met:

1. To have a plan that maximizes preparedness
2. To implement that plan fairly, paying particular attention to the formal requirement of justice to treat all human beings equally, or if unequally, then fairly based on a defensible standard.
3. To have an open, transparent planning and implementation process. This involves seeking input from stakeholders and providing clear rationale for allocation decisions. (Kinlaw & Levine, CDC, 2007: 3).

Implementation of Influenza Care Centers

As noted in the Santa Clara County ICC Plan, A flu pandemic will not be ‘hit and run,’ but will occur in waves over a period of a year or more. The ICC Plan assumes the worst case scenario for the worst case pandemic, i.e., demand for hospital beds, respiratory support, and basic medical care will far outstrip the supply. Health care needs will consume available human and material resources; many dilemmas will have no best outcome.

Children under 10 y.o. will not be admitted into an ICC. This is due to the need for standard orders in ICCs and the expected lack of experienced pediatric nursing personnel and pediatricians. Further preparedness requires provisions for treating infants and children when no pediatric beds are available in local hospitals.

(Mass Medical Care During an Influenza Pandemic, 2007).

Triage Guidelines: Scarcity of Resources

In pandemic planning, as in medicine in general, the allocation of scarce medical resources is one of the most difficult ethical issues confronting the health care system. Rationing occurs daily; the need escalates during a disaster. Because rationing is inevitable, it must be done in a manner that is fair, transparent, respectful of persons, inclusive, accountable, proportional, and minimizes harm. Current public expectations about access and the level of health care provided must change in light of the realities of a public health crisis.

Fairness is important on two levels: (1) the process by which decisions are made must be fair (procedural justice); and, (2) the distribution of scarce human and material resources must be fair (distributive justice).

Proportionality requires that restrictions to access to health care resources, limitations on individual liberty, and actions taken to protect the public from harm not exceed that which is necessary to maximize lives saved, protect societal functioning, and respond to the actual level of risk.

Fair Process (Procedural Justice)

When resources are scarce, procedural fairness requires that a triage protocol (Tool 7) be developed for guidance and consistency in resource allocation. From the point of view of procedural justice, the principle of distribution is not so much the concern as is the just application of that principle.

The primary objectives for the establishment of ICCs are congruent with fair process:

- Decompression of acute care hospital beds (receiving site for hospital discharge patients who are unable to be cared for at home), and
- Used instead of acute care hospital inpatient beds (inpatient care; moderate-acuity and palliative care). (Mass Medical Care, 2007: 8).

During ICC admission triage, patients will be assigned to either an acute or subacute ward, based on medical acuity, presence of co-morbid conditions, and level of nursing care. *Note: the intent of ICCs is to provide low-level supportive medical care to large numbers of ill patients who, under normal circumstances, may be treated as hospital inpatients. Basic medical care may include oxygen by nasal cannula and intravenous (IV) fluids.* (Mass Medical Care, 2007: 8).

If treatment proves ineffective, a patient may be placed in palliative care within the ICC. For those unlikely to survive, the ICC provides palliative care, facilitating patient comfort, family presence, and dignified death.

Due to the volume of patients that might be expected in alternate care sites such as ICCs, treatment is governed by standard orders vs. patient-specific. The majority of ICC patients are likely to be adults without co-morbid conditions. A patient determined to be ineligible for ICC admission will either be sent home with home care instructions or transferred to a hospital for a higher level of care. (Mass Medical Care, 2007).

ICCs embody fair process in the following ways:

- Maximize medical benefit to the overall patient population,
- Minimize harm to moderate-acuity patients,
- Seek a fair, efficient, and consistent distribution of scarce medical resources through a common triage protocol. This protocol will be active at all entry points, i.e., physician's offices, emergency departments, urgent care centers, 911 response, and ICCs. This uniform protocol (based on a modified pneumonia severity index calculation) forms the basis of a fair allocation process that assures consistency across people, access points, and time. In formulating explicit inclusion and exclusion criteria, the Clinical Triage Guidelines provide *clarity* and *transparency* to the medical decision making process. Medically similar cases are treated the same; medically unlike cases are treated differently, fulfilling the formal principle of procedural justice.

Fair Distribution of Human and Medical Resources (Distributive Justice)

In its discussion of allocation of resources, the CDC recommends that criteria for distribution should be clearly specified well ahead of the need to implement them. Allocation criteria should be directed at maximizing fairness (equity) in the distribution process. Equity in distribution of resources should take into account other checks ('side constraints') grounded in ethical principles of respect for persons, non-maleficence, and justice. The following questions should be asked to ensure fairness in distribution:

- What scarce goods are involved in the distribution plan? (e.g., drugs, antivirals).
- Who/what agency will decide prioritization and distribution? (interpretation of rules)
- Who is eligible to be a recipient? (e.g., local residents, visitors, etc.)
- What morally relevant criteria will be employed to assign higher or lower priorities to individuals or groups of individuals within goal of preserving societal functioning? (e.g., determining key services; order of priority within essential service groups) (Kinlaw & Levine, CDC, 2007: 6-7).

The ICC plan follows the recommendations of the National Vaccine Advisory Committee (NVAC) and the Advisory Committee on Immunization Policy (ACIP) to save the most lives by providing surge capacity to deal with flu sufferers who do not require traditional hospitalization. (U.S. Department of Health & Human Services, 2005). The triage protocol privileges those most likely to recover, i.e., those without significant co-morbidities.

Concentrating on saving the most lives, essentially classic utilitarianism, can produce consequences that are unjust for some. Classic utility would impose great harm on the few in order to maximize benefit to the majority. Recognizing this, the CDC recommends that the brutal effects of classic utilitarianism be modulated by the "side constraints" of justice, respect for persons, and the avoidance of harm. (Kinlaw & Levine, CDC, 2007:6).

The ICCP Triage Guidelines support the fair distribution of available medical resources by triaging patients to appropriate and available levels of care, including palliative care; this preserves scarce resources for those most likely to benefit and survive. The triage response must be proportional, denying hospital or ICC access only when resource limitations and the common good demand it.

Despite improvements in health care over the pandemic of 1918-1919, epidemiological models project 2-7.4 million deaths globally (WHO, 2005) and 1.9 million in America. (HHS, 2006).

Those who will not survive should neither be ignored nor receive scarce resources from which they are unable to benefit, such as a hospital bed. The needs of dying persons can be met through the provision of palliative care, minimally providing family presence and relief of pain and anxiety. Families may be reluctant for social, cultural, religious, and

practical reasons to have a loved one die at home. The availability of palliative care at an ICC fulfills the ethical obligation to treat the dying as persons deserving of respect.

Health care professionals are a resource that must also be allocated. Procedures that are customarily performed by certain professionals may need to be delegated to other categories of staff. Physician duties may be delegated to nurses, physician trained assistants, and other personnel, e.g., retired health care professionals, that are not part of the customary health care team. These delegations of responsibility and authority require careful planning. Appropriate training programs should be activated in advance of the pandemic. (CDC, 2007:7-8; Mass Care Plan, 2007). In September, 2007, the American Nurses Association addressed specific questions in a White Paper. Issues regarding the ethics and standards that apply to decisions about care during emergencies, disasters, or pandemics are discussed. The document speaks primarily to the individual professional in a caregiver or service provider role, whether:

- At the immediate site of a disaster at the time it occurs,
- At the usual place of work when it is affected by the disaster, or
- At some other site, due to relocation of work or work in a volunteer program/unit. (American Nurses Association, 2007).

ICC Admission

Questions related to admissibility of patients into the ICC will constitute a significant ethical concern. Limited resources and stringent admission criteria will likely mean that not all patients who apply for admission can be accepted into ICCs. When patients fail to meet the ICC eligibility criteria and are turned away, respect for persons requires that some process for appeal of the decision not to admit to an ICC should be available. Ethical preparedness includes procedures whereby individuals could fairly and rapidly initiate an appeal process.

Bed space may still be insufficient, even after basic eligibility requirements for ICC admission have been met. Further prioritization of patients will be needed. The American egalitarian instinct for fairness naturally inclines us toward seeking a fair, or equitable, distribution of the “scarce resource” of ICC access.

Making distinctions on the basis of social worth may be necessary in the event of pandemic flu. Failure to make these sorts of distinctions (giving priority, for example, to doctors, EMS workers, law enforcement personnel, vaccine scientists, firefighters, bus drivers, and sanitation workers) could translate into a high level of injustice accompanied by social chaos. This would exacerbate an already complicated situation. Prioritizing certain essential personnel, while unfair during non-pandemic conditions, may be the best way to minimize, and ideally avoid, further social breakdown during a flu pandemic. (Kinlaw & Levine, CDC, 2007:6).

Whichever prioritization categories are used, conversations about how to fairly rank individuals who meet the basic ICC eligibility requirements should be initiated in

advance of a pandemic. Such conversations should be carefully reasoned, transparent, and open to substantial public input. This will help ensure that the process is as fair as possible and avoid unnecessary discrimination. Moreover, a process that is transparent and open will help to bring the public “on board,” contributing to public understanding of and cooperation with any resulting prioritization rules or guidelines.

Other Issues/Considerations

In addition to operational planning for disasters, planners must consider the effects of repetitive stress and overlooked trauma in staff that respond to rescue and care for victims of pandemic flu. Responders helping people in distress may experience *compassion fatigue*. This is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper. In contrast to the person receiving help, the helper is traumatized via their own efforts to empathize and be compassionate. Poor self care and extreme self sacrifice may ensue; symptoms in the helper may be similar to post-traumatic stress disorder (PTSD).

(Compassion Fatigue: an Expert Interview, 2005:1).

The full implications and recommendations regarding compassion fatigue are beyond the scope of this tool. However, these issues have been incorporated into operational planning for Influenza Care Centers. This is partly accomplished via appropriate, scaleable numbers of mental health staff and critical incident debriefers, experienced and trained to work with staff in disaster situations. Mechanisms should be instituted to promote and monitor ethical principles of self care, maintain wellness, and reduce secondary traumatic stress reactions for disaster responders.

Next Steps

The ICC Plan seeks to provide the greatest medical benefit in the worst possible pandemic, in light of mandates for fairness in resource allocation and respect for persons. It recognizes that both planning and implementation will be riddled with difficult decisions affecting people’s survival and freedom at a time when the usual and customary rules and principles of medicine and ethics are suspended.

The need for pandemic preparedness extends beyond operational plans to include the underlying ethical values salient to their implementation. Tough choices need to be made during any crisis; a framework for ethical decision making should steer decision making, provide consistency across contexts, and encourage accountability. A shared ethical framework may help to mitigate the unavoidable painful consequences of triage and social distancing decisions during a pandemic. Key questions include:

- How to make an ethical framework operational on a local level?
- If shared values and principles are to guide decision making, how ought this happen in a transparent and accountable way?

The application of an ethical framework is also pivotal. Key decision makers and first responders need training in the same way that they need disaster-preparedness drills.

Hands-on “ethics drills,” based on case studies, could increase preparedness for difficult decision making on the front lines of a public health disaster.

- Inherently controversial subjects such as determination of social worth, and even triage protocols, should be thoroughly and publicly scrutinized *before* a crisis. Public trust is essential to the successful planning and implementation of disaster plans.
- Clear mechanisms should be developed for public education and comment before, during, and after the planning process. Diversity must be included in stakeholder discussions. Heavier burdens are more likely on the poor and marginalized.

These suggestions for ethical next steps build on the significant work already done by governmental agencies, both nationally and globally. The Influenza Care Center Plan should be seen as a living document, subject to change before, during, and after a pandemic in light of new information and realities.

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